

Reproductive, Maternal and Child Health issues – post tsunami experiences in Sri Lanka

I share with you our experiences in Sri Lanka following the tsunami that struck us on December 26th last year.

The tsunami left us a legacy of numerous problems and as in any disaster mothers and children were among the worst affected. Children focused prominently throughout this disaster and an array of unique issues involving the birth plan, the newborn and the health of the mother, as well as nutritional aspects, child protection and fostering services will be described.

Paediatricians are first line responders in any emergency, but my presentation involves issues relevant to several agencies, relief workers and policy makers. In keeping with the theme of this conference I will highlight what was achieved and how the outcome could have been improved, with regard to children and mothers in the Sri Lankan scenario.

In the rescue phase, lack of disaster preparedness was a major drawback. The impact could have been reduced with public awareness of tsunami behaviour, and better communication. Many more lives could have been saved had there been public understanding and utilization of indicators such as the receding sea, the time interval of over 20 minutes between the first wave and the subsequent killer waves, and lag time of 40 minutes between the waves in the eastern and southern coasts of Sri Lanka. Nature's warnings were not understood. A National Disaster Preparedness Plan and public awareness on disaster management are essential requirements. Children carried in to hospital in the supine position whilst frothing at the mouth following near-drowning is one example that highlighted the need for capacity building at community level. Communities responded remarkably well but for more effective rescue and evacuation, training is necessary. Dearth of paramedics and paediatric intensive care facilities increased the number of child deaths.

In camp situations a positive feature observed was the priority given to women and children. Female volunteers were recruited for protection of children and distribution of supplies. Anecdotes of violations of child rights such as child trafficking, baby snatching, sexual assaults and child conscription were reported, as is wont in any disaster or complex humanitarian emergency; but the availability of the National Child Protection Authority (NCPA), an organization established prior to the Tsunami, by an act of Parliament with a clear mandate for dealing with child protection issues helped in their prevention and management. The task of identifying unaccompanied minors was carried out by the Dept of Child Probation, UNICEF and the NCPA. At present the number of children rendered destitute with loss of one or both parents is reported as 6800, but duplications in the count are still being verified.

The fight to stay ahead of infections, an absolute necessity in temporary shelters and refugee camps met with success in Sri Lanka. An effective disease surveillance rushed in by the Ministry of Health and WHO achieved this. Special notification forms on epidemic prone diseases, daily updates on composition of camp and its characteristics such as water supply etc and good coordination between central and local health authorities were some of the mechanisms used. The pre existing high level of immunization coverage of children BCG 99.5%, DTP/OPV (3rd dose) 99.9%, Measles 101% , and a literate population well motivated to accept health messages also helped avert outbreaks of communicable diseases. Childhood illnesses did not become problematic although diarrhoeal episodes were reported in 1/5th of children and acute respiratory infections in 2/3rd of under fives. Health services

were restored or remained functional in most areas although greater access to the rebel held areas in the North and East of the country would have been desirable.

Surveys on the impact of the disaster on the nutritional status, two to three months after the tsunami indicates a marginally higher than national average for chronic PEM (30%) and an increase of acute PEM from 14% to 16%. Concerns on vitamin A status has resulted in launching a UNICEF funded one day Vitamin A campaign.

Indiscriminate distribution of formula food by well wishers occurred in the first week or two but was strongly advised against by the medical profession and effectively stopped. The nutrition related issues that were embarked upon were promotion of breast feeding and guidelines on feeding infants and under fives issued to Medical Officers of Health (MOH) by the Family Health Bureau of the Ministry of Health advised on giving priority to pregnant and lactating mothers and infants and young children. Health staff and volunteers were asked to actively support the continuation of breast feeding, discourage bottle feeding and even if mixed feeding had commenced to attempt to revert back to breast feeding only. The MOH coordinated with the Divisional Secretary to ensure a regular and adequate supply of food to all camps and temporary settlements. Public Health Midwives visited all families having children under five years of age and all children who had lost both parents or the mother, whether they were living in camps or with relatives; and discussed in detail the optimal feeding practices. Complimentary food and food appropriate for children between one and five were prepared centrally under strict hygienic conditions.

Arrangements were made for pregnant mothers to attend antenatal clinics in the nearest institution and when this was not available the MOH conducted clinics within the camp. Antenatal cards if lost were replaced and updated, high risk mothers identified and referred appropriately and a birth plan made for each mother with her participation. Iron, multivitamins and nutritional supplements, clothing and other requirements for the baby and mother (sanitary pads etc) were distributed, tetanus toxoid given and blood grouping and Rh estimated in the field setting by mobile laboratory services. Anthelmintics were recommended for all pregnant mothers. Volunteers were asked to promote breast feeding and safeguard mothers against pressures from milk food companies. Hospital staff cooperated by extending the postnatal stay as needed for social reasons and many mothers were found homes in the neighborhood by the MOH instead of returning to camp. Field visits by the midwife were regular and daily and mental health of the mother was an added priority. Recognising a depressed mood, over anxiety and sleep disturbances and providing reassurance and family support were sufficient in the majority of cases in the initial two months. However remaining in temporary shelters and camps is affecting the morale and mental state. Housing, urgent resettlement and a sense of social security is absolutely essential and is an area in which intervention is suboptimal.

One thousand children in Sri Lanka lost both parents to the Tsunami. The scale of the problem of reuniting unaccompanied minors with families was unprecedented with no blueprint to follow. The evidence base on Aids orphans in Africa had transferable messages with many obvious differences. The options available were institutional care, adoption, or foster care. Institutionalization, being devoid of affection and a sense of belonging to a family was from the child's point of view the least favoured. Every effort is being made to minimise orphanage stay. Adoption, i.e. legally creating a parent-child relationship between persons not biologically connected was not recommended until two years after the disaster for several reasons. The possibility of one or both parents being found eventually and the adoptive parents being themselves emotionally affected and not suitable for a legally binding long term commitment were among these. The current law in Sri Lanka had its limitations such as a statutory age limit of 14 years with need to increase the permissible age. The next best alternative was foster care. The majority of children were accepted

voluntarily into their homes by surviving relatives. Culturally this arrangement of living with an aunt or uncle is both familiar and acceptable. The government agents maintained a register of all custodians of children under the age of 18 years. Every person who had in his care, custody or control any child of whom he was not the natural parent, had a duty to register himself with the Government Agent of the district. This process of fostering is not a legal arrangement yet because the existing legislative enactment, The Children's and Young Persons Ordinance was considered inadequate in determining a Fit Person for role of foster parent. The Ministry of Justice drafted new legislature specific to tsunami affected children and the Sri Lanka College of Paediatricians stipulated minimum standards for fostering services and care. These included characteristics of suitable parents, family, home environment, meeting educational, developmental and health needs, protection from abuse and neglect, safeguarding child rights etc. The new Bill that is now before parliament will accommodate a nominee from the Sri Lanka College of Paediatricians to function on the panel of evaluators deciding on suitability of a foster parents. The sooner the foster care arrangements are legalized the better since movement from one care arrangement to another is known to be damaging to the child.

A sponsorship scheme providing financial support to the foster family has been launched. A few trusted agencies, including the College of Paediatricians have volunteered to help in this task. A standard monthly amount has been decided on, and sponsors are currently being enrolled but with no direct contact with the child being permitted at present.

The Dept of Child Care and Probation and NCPA have the mandate to monitor the progress of children through peripheral units that are yet to be set up in each affected area.

With regard to psychological impact, within a week of the disaster a fact sheet on recognizing a child who is psychologically affected and meeting his /her needs was distributed to the camps in all affected areas. Several workshops were conducted on basic principles of psychological first-aid, breaking news, developmental stages of a child's understanding of bereavement and preventing re-traumatization. The role of schools in returning to normalcy was appreciated and schools reopened on January 15th. However there are a few schools which are still refugee camps hindering this vital source of healing for children. Schools have been instructed on post disaster activities that facilitate healing and in identifying high risk and psychologically affected children. We hope that with these measures the magnitude of post traumatic stress disorder could be reduced to a single digit percentage among the affected children.

A book written in simple non-technical language on Children Affected by Disaster – Post tsunami Paediatric Perspectives covering all aspects of the tsunami disaster was launched by the end of March 2005.